Journal of the American College of Cardiology Vol. 54, No. 6, 2009

Published by Elsevier Inc.
ISSN 0735-1097/09/$36.00
doi:10.1016/j.jacc.2009.05.010

VIEWPOINT Health Reform

Professional Accountability in Health System Reform

James T. Dove, MD,* W. Douglas Weaver, MD,† Jack Lewin, MD‡

Springfield, Illinois; Detroit, Michigan; and Washington, DC

The momentum for health system reform continues to gain support and cooperation from many groups who were opposed to reform in the past. The uninsured and underinsured numbers have increased with the rising cost of health care and the worsening economy. Designing a health care delivery system that delivers quality patient-centered care will require the direct involvement of patients and medical professionals. The American College of Cardiology is recognized for its commitment to education and quality and a commitment to quality metrics that facilitate best practice. The American College of Cardiology needs to continue its leadership role to ensure that health care reform meets the expectations of our patients and members. (J Am Coll Cardiol 2009; 54:499–501) © 2009 by the American College of Cardiology Foundation

Health care in the U.S. in many ways is the best in the world. Significant advances have been (and continue to be) made in the treatment and diagnosis of cancer, cardiovascular disease, stroke, and other life-threatening diseases. Over the past 30 years, we have seen mortality from cardiac disease and stroke decrease by 60% and 70%, respectively (1,2). These dramatic results reflect the benefits of public education and awareness combined with new pharmaceuticals, devices, and treatment strategies. Unfortunately, however, our current health care system does not always facilitate our ability to deliver high-quality, cost-effective, and continuous care.

There are more than 46 million uninsured and just as many or more underinsured. During the first American College of Cardiology (ACC) Health System Reform Summit in February 2008, health policy leaders warned that employees, while concerned about the uninsured, were more worried about losing their own coverage. Given the current economy, these worries have become reality for many. According to health care economist Uwe Reinhardt, PhD, of Princeton University, it costs $15,600 out-of-pocket for a family of 4 to pay for health care (3). Health care costs are pricing the bottom one-half of the American income distribution out of affordable health care.

Besides coverage, or lack thereof, there are wide variations across the country in outcomes, quality, and use of medical resources. Many explanations for these variations have been proposed, including the need for defensive medicine because of high medical liability premiums and a legal system that is out of control, patient self-referral, and regional practice styles. There are many reasons for care variations and increasing health care costs that are outside the control of the individual physician. These represent social service lapses, and uninsured Americans seeking care late in their illness when the disease may be more complex. The U.S. health care system, however, compares unfavorably on many measures with other health care systems in the Western world. The U.S. is viewed as inconsistent because it fails to deliver the minimum, evidence-based care to everyone, while it delivers too much discretionary care for cases in which the supporting evidence is limited (4,5). The current payment models lead to costs that society and employers can no longer afford. We must take responsibility for reducing the high costs that we can control such as those associated with duplication, overuse, and a lack of coordination of care. We must also address the underuse and failure to adhere to proven medical regimens. We can do better and must become good stewards in the use of health care resources.

To this end, the ACC is taking a leading role in health care reform efforts by engaging patients, lawmakers, payers, and other stakeholders around a new standard of health care delivery centered on increasing the quality of care and ensuring greater patient value. Under the organizing principle of "Quality First," the ACC is encouraging health care providers to act on their professional responsibility and transform health care from the inside out. We, as physicians, with other members of our health care team, are on the front lines of care delivery and can do better in applying guidelines and appropriate use criteria and using registries to guide our decision making and improve patient care.

Over the last 60 years, the ACC has become a recognized leader when it comes to education and quality. Today, the ACC/American Heart Association guidelines, ACC appropriate use criteria, performance measures, process measures, and the National Cardiovascular Data Registry continue to be recognized for their contributions toward improving patient care. With momentum for health system redesign continuing

From the *Prairie Cardiovascular Consultants, Southern Illinois University School of Medicine, Springfield, Illinois; †Henry Ford Heart and Vascular Institute, Detroit, Michigan; and the ‡American College of Cardiology, Washington, DC.

Manuscript received April 23, 2009; accepted May 9, 2009.

Abbreviations and Acronyms

ACC = American College of Cardiology

IT = information technology

to build, these tools and the ACC's experiences in implementation and use will be instrumental in defining the physician's role in health care reform. Unlike past efforts to reform health care, groups that in the past opposed reform have come forward in support of it with new ideas and a willingness to participate. Most realize that we cannot continue our current course of increasing costs and decreasing coverage. The current economy, while also an impediment, is also creating new opportunities for partnerships and action.

Recognizing this opportunity for partnership, as well as the need for the public and members of the health care team to be the architects of any new delivery system, the ACC in March 2009 reaffirmed its commitment to health care reform by approving 6 principles necessary for reform, including:

- Universal coverage
- Coverage through an expansion of public and private (pluralistic) programs
- Focus on patient value—transparent, high-quality, cost-effective, continuous care
- Emphasis on professionalism, the foundation of an effective partnership with empowered patients
- Coordination across sources and sites of care
- Payment reforms that reward quality and ensure value

While the coverage and financing are critical, health care providers can have the most impact on the last 4 principles, which are focused on delivery system improvement and patient empowerment. In addition, a renewed focus on measurable health outcomes, a reduction in legal and defensive medicine costs, a promotion of clinical comparative effectiveness, and a focus on projected workforce needs must be part of any overall reform.

The implementation and use of health information technology (IT) are also key to the systematic practice of quality. The Obama Administration has provided $20 billion for health IT. Health IT systems are the foundation on which to build a better health care delivery system that increases coordination across sources and sites of care, decreases duplication, and improves efficiency. To be successful, however, they must be interoperable and provide decision support tools at the point of care. Without these elements, health IT becomes just another promise.

Likewise, there needs to be payment reform that rewards quality of care and best practices rather than just the number of patient contacts. We have a perverse payment system that fails to reward adequately those working hard to provide total patient care, consultation, and prevention. Provider payment systems must be redesigned with the patients' interests in mind.

The ACC supports payment reforms for improved coordination of care, team-based care delivery, and the appropriate use of tests and procedures. There should be disincentives for care providers—and patients themselves—who over- or underuse tests and technologies. In addition, we can reduce the rate of increased spending by rewarding for value-based care. We can offset any losses through the added payments we receive when more of this country is insured and when incentives for quality system development are in place. The ACC also supports the patient-centered medical home idea, as long as it is recognized that specialty-centered medical homes are necessary for some patients and practices.

The ACC was founded 60 years ago on the basic premise of quality education and individual self-improvement. As a professional society, it became more active in health policy when it was obvious that the voice of cardiovascular specialists was necessary to ensure that health policy improved health care for patients and preserved access for them. The ACC continues to be a leader in education, self-improvement, and quality initiatives. It is also a recognized proponent of health care policy and a leader in quality development.

Moving forward, the ACC is committed to furthering quality applications within the clinical setting and expanding our guidelines, performance measures, appropriate use criteria, and the National Cardiovascular Data Registry. It is what our members expect and what the public deserves. The ACC has developed a series of action plans in areas where we believe we can make major contributions in both cardiovascular care and overall system reform. The plans focus on reducing cardiovascular-related hospital readmission rates, limiting inappropriate imaging, reducing geographic variations in care, encouraging adherence to guidelines, partnering on patient-centered medical home models, ensuring transparency and professionalism, testing payment models that reward quality, and increasing primary and secondary prevention through medication adherence and lifestyle choices.

The ACC firmly believes that carefully crafted partnerships among patients, the Centers for Medicare and Medicaid Services, Congress, the Obama Administration, willing professional societies, and patient-centered interest groups are critical to enacting real reforms and expediting the progress needed. Each of the ACC's principles and proposed pilots is designed to move the cardiovascular community—and the nation as a whole—even closer to ensuring the right care, to the right patient, at the right time.

We have a major challenge ahead in alerting our colleagues about the inevitability of significant health care reforms. We will not like everything that is coming, and therefore we must remain focused, involved, and prepared to lead. It is our responsibility to ensure that any reforms are practical and appropriate for cardiovascular patients and practices.

Throughout the rest of the year, the greatest challenge for both the ACC and the medical community will be to remain nimble in the face of change. Health care reform will likely require physicians and care providers to adjust the way they practice. Ultimately, we must remain committed to doing what is right for patients as we engage in the great effort to reform health care. To that end, the ACC is at the

health care reform table representing our patients and you. This is where we belong, and we will be there as long as our positions are credible and our intent sincere.

Reprint requests and correspondence: Dr. James T. Dove, Prairie Cardiovascular Consultants, Ltd., 619 East Mason Street, Suite 4P57, Springfield, Illinois 62701. E-mail: jdove@prairieheart.com.

REFERENCES

1. Weisfeldt ML, Zieman SJ. Advances in the prevention and treatment of cardiovascular disease. Health Aff 2007;26:25–37.
2. Ford ES, Ajani UA, Croft JB, et al. Explaining the decrease in U.S. deaths from coronary disease, 1980–2000. N Engl J Med 2007;356: 2388–98.
3. Reinhardt U. Dack lecture. Presented at: ACC Annual Scientific Sessions; March 29, 2009; Orlando, Florida.
4. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. Ann Intern Med 2003;138:273–87.
5. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. Ann Intern Med 2003;138:288–98.

Key Words: health system reform ■ professional responsibility ■ American College of Cardiology.